

## DRAINAGE OF THE PREVESICAL SPACE THROUGH THE PERINEUM IN SUPRAPUBIC CYSTOTOMY.\*

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SUPRAPUBIC cystotomy admittedly affords the best access for intravesical operations; and when primary union of the incision is secured, leaves nothing to be desired.

Usually, primary union is not secured nor even attempted; and since drainage of the urine through a suprapubic tube—*i.e.*, against gravity—is a failure, leakage into the prevesical space commonly occurs in spite of the many ingenious devices intended to avert it, including the purse-string suture and siphon drainage. Stagnation of urine in this space invites infection, sepsis, pneumonia, and compels prolonged confinement to bed. Hence the mortality of the suprapubic is in elderly patients distinctly greater than that of perineal incisions for the same purpose, notably prostatectomy.

In spite of this greater mortality, suprapubic has largely superseded perineal prostatectomy in Europe, because the latter operation, by transforming the perineum into cicatricial tissue, entails so many distressing sequelæ—perineal and rectal fistulæ (in 8 per cent. of 2,000 cases), permanent incontinence of urine (3 per cent.), cicatricial contraction of the prostatic urethra, besides impotence, epididymitis and other minor ailments.

Stagnation of urine and tissue fluids in the loose prevesical tissues can be prevented in two ways: (1) By abolishing and (2) by effectively draining these tissues. Abolition of loose tissues is secured by making the operation in two stages, five days apart; when this is done under nitrous oxid anaesthesia the risks are minimized.

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The obvious objections to this method are avoided by the other plan, which, so far as I can learn, has not yet been recorded nor practised. This consists in drainage of the prevesical space into the perineum—at the bottom instead of the top—with complete closure of the suprapubic wound. The procedure is this: When the operator is ready to close the wound, the membranous urethra is opened on a grooved staff, the gorget introduced and staff withdrawn; a small trocar and canula is passed from above along the anterior surface of the bladder and prostate into the groove of the gorget. The trocar being withdrawn, a few silkworm strands are threaded through the canula and along the gorget out through the perineal wound (a small perforated rubber drain may be attached and drawn through by the threads). A large, soft catheter with multiple perforations having been introduced into the bladder for perineal drainage, the suprapubic incision, bladder and abdominal wall are closed completely except where the threads protrude, the anterior bladder wall being anchored near the recti muscles. Urine which may leak through the bladder wound, and tissue fluids, find ready exit at the bottom of this space.

In nine of eleven cases in which I have made this operation the wound has been entirely healed within two weeks; in the remaining two—prostatectomies in which oozing blood was allowed to block the perineal drain—the wound was reopened for the insertion of a larger drain. Greater care in cheeking oozing with formalin gelatin, should prevent this mishap.